

Form Instructions

For Providers of Laboratory Services Completion of the Advance Beneficiary Notice (CMS-R-131-L).

Upon final OMB approval of the Advance Beneficiary Notice (ABN), complete instructions will be formally published in the Medicare Carriers Manual, the Medicare Intermediary Manual, and relevant Provider Manuals. The manual instructions will be the official Medicare program promulgation of policy and procedures that providers (viz., physicians, practitioners, suppliers, and providers under Parts A and B of Medicare) and Medicare carriers and fiscal intermediaries are to follow with respect to ABNs.

i. Header of ABN--

- a. Header top--Put your (provider's) name, address and telephone number at the top of the page of the notice; including your logo (if any). In the case of a laboratory providing ABNs to physician clients, the laboratory's identifying information, not the physician's, is included in the header.
- b. "Patient name" Line--Enter the name of the patient; do not substitute the name of an authorized representative.
- c. "Medicare # (HICN) Line--Enter the patient's Medicare health insurance claim number.

ii. Body of ABN--

- a. In the section beginning "Medicare probably will not pay...", specify the laboratory tests for which you expect Medicare will not pay. Describe the laboratory tests at issue in sufficient detail so that the patient can understand what laboratory tests may not be furnished. The use of standard laboratory test descriptions is permitted. HCPCS codes by themselves are not acceptable as descriptions. This ABN has been designed with three columns with the specific reasons for expected denial captioning these columns. Enter or preprint laboratory tests in these three columns; the use of check off boxes is permitted. This format allows you to customize the ABN with a preprinted list of tests linked to the captioned reasons for denial. If you customize this ABN for your own use, any pre-printing should be in at least 12 point Arial or Arial Narrow font or a similarly readable font.
- b. "Estimated Cost" Line--You may provide the patient with an estimated cost of the test(s).
- c. Options 1 & 2 Boxes--Have the patient select an option.
- d. In the "Date" blank, the patient, or person acting on his or her behalf, enters the date on which he or she signed the ABN. In the "Signature of patient ..." blank, the patient, or person acting on his behalf, must sign his or her name.

iii. Disclosure--

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566.

The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection.

If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.